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ABSTRACT

This practicum was designed to create an organizational model that would set the stage for the creation of a comprehensive program of substance abuse treatment in a residential setting. The subject population was women ages 15 to 25 years, who had children or were pregnant and who demonstrated patterns of substance abusing behaviors. This writer developed a database professional organizations and practitioners to determine the feasibility of the suggested model treatment program. With the input received, a non-profit organization was created to formalize the basis for program development, long term and strategic planning and the meeting of all licensure requirements. Input was also received by graduate schools of social work and professionals in the substance abuse treatment field, focusing on the menu of services and treatment modalities. Analysis of the data and input collected revealed new possibilities for an organizational design to be used as the basis for a comprehensive treatment model. Through the implementation of the organizational design, it was determined that the comprehensive treatment model proposed would provide the broadest continuum of services offering the best chance for client success. (Author/RB)

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An Organizational Model for Long-term Residential Substance Abuse Treatment for Women, Ages 15 to 25 Years, and Their Infant Children

by

Ronald F. Bailey

Cluster 44

A Practicum II Report Presented to the
ED.D. Program in Child and Youth Studies
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

NOVA UNIVERSITY

1993

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PRACTICUM APPROVAL SHEET

This practicum took place as described.

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Approved:

11-29-93

Date of Final Approval of Report

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Dr. B. Matthews Hill, Advisor

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ABSTRACT

An Organizational Model for Long-Term Residential Substance Abuse Treatment for Women, Ages 15 to 25 Years, and Their Infant Children. Bailey, Ronald F., 1993: Practicum Report, Nova University, Ed.D. Program in Child and Youth Studies. Teen Parents/Substance Abuse Treatment/Residential Treatment Facilities.

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Analysis of the data and input collected revealed new possibilities for an organizational design to be used as the basis for a comprehensive treatment model. Through the implementation of the organizational design, it was determined that the comprehensive treatment model proposed would provide the broadest continuum of services offering the best chance for client success.

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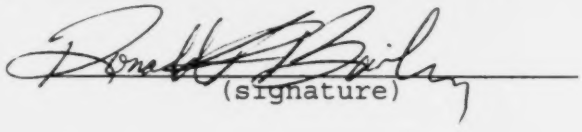 (signature)

CHAPTER I

INTRODUCTION

Description of Work Setting and Community

The work setting for the writer is an adolescent mother/baby advocacy group. Those participating in the advocacy group represent social services, educational and church professionals. The advocacy group came together to discuss the issues around adolescent mother/baby needs, to determine how their needs are being addressed and what could be done to provide long term resolution to some of the concomitant problems associated with adolescent child bearing. The advocacy group is located in a region with rural and urban characteristics. Because of the regional representation of the advocacy group, it was decided to approach the group's objectives with a regional focus.

Adolescent females between the ages of 15 and 25 years are the subjects of the group's efforts. Each of these adolescents is a chemical substance abuser, has a history of chemical substance abuse, or is at high risk of future substance abuse. Each female is pregnant or will have already given birth to at least one child

It was expected that those mother/baby units served by the advocacy group would be equally representative of the rural and urban settings in the region being served. In a less direct way, but none-the-less intentionally, the family systems of origin of the adolescent mothers would also be offered treatment services. It was expected that most of the adolescents served would come from dysfunctional families.

Writer's Work Setting and Role

The writer is the Executive Director of the advocacy group and has been given the mandate to create a model program and subsequent non-profit agency to meet the needs of adolescent mothers and their infant children. As the Executive Director, the writer had the direct responsibility to create a Board of Directors, facilitate legal incorporation and achieve an appropriate Internal Revenue tax code exemption. In addition, the writer was responsible for acquiring appropriate licensure from appropriate governmental agencies and to hire professional and ancillary staff to operate the program in line with governmental mandates.

Because the program does not exist, the focus of

this practicum and the immediate tasks of this writer were to develop a model for the administration and implementation of a comprehensive social services program for adolescent mothers and their infant children. The writer was accountable to a board of directors which took the place of the advocacy group which provided the initial impetus for the development of the formal organizational model.

The writer has had direct experience in working with this client population in foster care and community social work settings. This experience was essential, not only to the role of the writer in designing the program, but also in interpreting the program goals and objectives to the professional community and to the community at-large. Development of funding streams and political support required the writer to be intensely involved with community and governmental structures.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

Current organizational models have been ineffective for the delivery of treatment and social services to teenage drug-abusing mothers and their infants. Comprehensive programs for adolescent mothers and their children are woefully lacking both in quantity of programs available and the quality of services provided. There are a significant number of mother/baby programs operating across the United States; however, most of these programs focus on women over the age of 18. In addition the programs that do exist often have a very narrow focus which would preclude a substance abusing mother from having her child with her while in treatment, or an adolescent mother having her child at all. Many of the programs that exist have a very narrow menu of services such as drug recovery, and either education, parenting skills or vocational training rather than offering comprehensive services.

An additional problem that is common in adolescent

mother/baby programs is that they only provide residential services for a short period of time, usually six to nine months. If during this six to nine month period, a presenting problem such as drug abuse is addressed and the other social, emotional and economic issues which precipitated the initial substance abuse are not addressed, then the adolescent will be at a high risk of relapse. Consequently, the adolescent mother is often found to be inadequate to meet the needs of her child, and the child may typically be placed in foster care. Because the mother/baby bond is broken, the adolescent mother often takes on an "off the hook" attitude and increases the behaviors that led to the bond being broken. If this process goes on long enough, the damage to the family is often irreparable.

The lack of comprehensive social services programs has been, in large part, an administrative problem. Comprehensive social services programs have been lacking because adequate administrative and program sustaining models have not been readily available. In large part this is because governmental bureaucracies have made it difficult for service providers to provide

a multiplicity of services. The need for multiple licenses, and overlapping legal mandates make program implementation difficult and far from cost effective.

Administrative structures must be designed to be compatible with the mission of the program as well as a specific organizational culture. A well defined program will attempt to create an atmosphere conducive to carrying out its mission. However, in the case of a residential treatment facility, a major objective would be to create a supportive nurturing environment rather than a methodical, sterile environment as would be suggested by governmental institutional guidelines.

Communities, governmental entities and adolescent clients often become frustrated with current treatment efforts because of the high costs and marginal outcomes of the programs. The introduction of yet another program model will be difficult unless cost effectiveness can be demonstrated. While it is true that a comprehensive social services program would have a higher implementation cost, it must be shown to be the best alternative for treatment and future economic benefit. Comprehensive programs for adolescent mothers and their babies need to become normative rather than

exceptional.

Problem Documentation

Evidence of this problem is supported by observation, informal surveys, and statistical data. Over a 15 year period, this writer has been directly involved with the adolescent female population in rural and urban settings. Most of the writer's involvement took place in cross-cultural settings. It is this writer's observation that those female adolescents who had a child and were served by a program designed to prepare the mother for parenting and self-sufficiency left the program ill-equipped to function in society upon discharge. It has also been observed that the mother/baby unit is often readmitted for further services as a direct result of the first program's initial failure.

Colleagues of the writer in the social work and psychology professions who work with the adolescent mother population frequently express their frustration over the lack of comprehensive services programs available to them for client referral. Adolescents who interact with these helping professionals also become frustrated because they are unable to meet the demands

placed upon them by the system to graduate to a level of independent living. Informal surveys of helping professionals and adolescent females both indicate strong support for a residential program which provides comprehensive social services.

Based on statistical data from the Center for Population Options, The Education and Human Services Consortium and the Human Organization Science Institute, it can be shown that programs for adolescent females with substance abusing behaviors who have a child or are soon to have a child are lacking both in quantity and quality. These statistics also show an increase in the numbers of this high risk population.

The Human Organization Science Institute performed an independent research study for the state which is the focus of the advocacy group (Kelley, 1990). The study showed that there were a total of 709 service providers in drug and drug/alcohol treatment. Of the 709, none provided comprehensive services for adolescent mothers and their infants using a long term residential comprehensive services model.

The Center for Population Options (1991) reported that in 1988, 488,941 babies were born to teenage

mothers. They have also substantiated a link between drug/alcohol use and unplanned adolescent pregnancies. Their studies show that almost one half of pregnant teens interviewed were using alcohol and/or drugs before the act of intercourse that resulted in the pregnancy. Further, they found that adolescent male and female crack users had heightened sexual activity and had numerous sexual partners. While the studies cited were based on a national sample, regional and state studies by The Center for Population Options have substantiated these findings as well.

Melaville (1991) writing for The Education and Human Services Consortium found that there were five core reasons why comprehensive services programs are not being effectively used. First, most services are crisis-oriented. By their very design, most programs seek to address a problem after it has occurred rather than being preventive in nature. Second, the current social welfare system divides the problems of children and families into rigid and distinct categories that fail to reflect their interrelated causes and solutions. A third reason for the current system's inability to adequately meet the needs of children and

families is a lack of functional communication among public and private sector agencies. Often differences in professional orientation or institutional mandates cause agencies to take an adversarial role toward other agencies. Fourth, the current system falls short because of the inability of specialized agencies to easily craft comprehensive solutions to complex problems. Offering an adolescent mother employment training without offering child care fails to make access to services viable for the client. Fifth, existing services are insufficiently funded. At current funding levels, only a small percentage of children, youth and families can receive the necessary services and treatment to address years of neglect.

Clearly, there is sufficient evidence to support the need for comprehensive services to adolescent mothers and their children. While there are numerous programs, as cited by Kelley (1990), none exist to serve adolescent mothers with drug abusing behaviors who want to keep their babies. The increase in the number of teen pregnancies and the accompanying use of drugs and/or alcohol prior to intercourse support the need for comprehensive treatment services. Because the

lack of comprehensive services appears to be a systemic problem, it is vital that new models be created and implemented in order to offer alternative holistic approaches to human services.

Causative Analysis

It is the writer's belief that there are six causes for the current lack of effective comprehensive models for the treatment and social services delivery to adolescent drug-abusing mothers and their infants. First, because children are not a political force to be reckoned with, funding for demonstration projects is woefully lacking and disproportionate to the need. Until government officials become aware of the political/economic payoff of providing adequate levels of funding, it is not likely that comprehensive services models will find enough support to succeed. Second, models for effective comprehensive programs are not being developed because current policy and contract mandates at the state and local levels only pay for specific services. Most funding provides treatment at the point of crisis rather than investing in long-term holistic care. A third reason for the lack of comprehensive care models is that the social services

community often does not have the managerial skill to develop an organizational model to support a comprehensive treatment program because managers often arise from the ranks of treatment professionals, not from the business community.

Adolescent mothers participating in crisis treatment oriented programs often become pregnant again during their teen years. This fact gives rise to a fourth cause for the lack of comprehensive treatment models. The general population has misgivings about supporting more costly programs because of past program failures. This is a salient point because adolescent addictions and birthing have been present in the societal fabric for many years, enough that this pattern is repeating itself generationally.

A fifth cause for the lack of comprehensive treatment models is that it is more expedient to offer in-home and out-patient programs because they cost less to operate. However, operational costs cannot be used to qualify results as well as it can to quantify the number of clients served. There is no cost saving justification if adolescent mother/baby programs only address the immediate crisis and then refer the

client(s) to the next helping agency. A residential, comprehensive services model requires a full menu of services to ensure client self-sufficiency upon discharge. It can then be argued that the comprehensive services model in effect costs less when the total costs to society are considered.

The sixth cause for the lack of comprehensive services models is that attempts are being made within the school system to provide an array of social services to pregnant teens on an out-patient basis. In those situations where the pregnant teen is only in need of educational, prenatal and counseling services, the school setting may be adequate. However, when the adolescent is confronted with abject poverty, poor housing, illicit drug abuse and a dysfunctional family, success in the school setting would be improbable at best. Residential, comprehensive models can offer the time and intensity needed to prepare the adolescent mother for adult and parenting roles.

Relationship of the Problem to the Literature

A review of the literature has confirmed that there is a lack of adequate models to address the needs of drug-abusing adolescent mothers and their infant

children in a comprehensive manner. It is also apparent from the literature review that very little is being done to encourage new models and that the corpus of the literature offers little new information about existing comprehensive programs even though the elements of such programs are identified.

The extent of the problem can best be seen by examining the potential clientele for a comprehensive program model. In a study done by Gomby and Shiono (1991), it was estimated that, within the total population of the United States, between 554,000 and 739,200 pregnant women used chemical substances during a one year period. Of all newborns in the United States 2% to 3% are exposed to cocaine and 3% to 12% are exposed to marijuana. Cigarette and alcohol exposure occurs among 38% and 73% of all pregnancies respectively. It was determined that pregnant adolescents use chemical substances in proportionate amounts to the general population of pregnant women in the United States.

Consistent with the above findings were those of Flanigan (1990). He determined that in cases of unintended adolescent pregnancies drugs and/or alcohol

were used just prior to the intercourse resulting in the pregnancy 50% of the time.

Kelley (1990) in an independent research study for a mid-Atlantic state determined that comprehensive residential treatment programs for pregnant or parenting mothers with a history of substance abuse were lacking state wide. In his review of comparative programs in the mid-Atlantic region he came to the same conclusion. In a compilation of state wide facilities and services, the Department of Health, Office of Drug and Alcohol Programs (1991) came to a similar conclusion for the state studied by Kelley. Beyond Kelley's findings, however, the state's study found no comprehensive residential treatment program for adolescent mothers and their infant children that have been exposed to chemical substances.

The Children's Defense Fund (1987) has identified specific barriers common to child care programs that serve adolescent mothers and their infants. First, limited funding requires agencies to seek monies from a wide variety of government, private, foundation and corporate sources. Because provider reimbursement rates are so low, agencies must have an ongoing fund

raising effort or curtail services to balance their budgets. Second, it is difficult to build a case for comprehensive programs because of the lack of valuative data. Few longitudinal studies have been done on the adolescent mother population and their rates of success in different types of programs. Third, the physical space required for such a program is hard to obtain due to costs and licensure requirements. Historically single solution programs have lacked coordination with other helping agencies, further hindering the client's ability to maneuver through the maze of bureaucratic institutions on their way to independence. A fifth barrier is probably the most difficult to overcome: the problem of community resistance. When a viable program site is found, it is not uncommon for the community to rebuff the agency's attempts to establish a program often out of their desire to punish teen mothers for their mistakes.

In addition to the barriers cited above, The Children's Defense Fund (1987) has found that programs which offer quick single solutions to multidimensional problems often exacerbate the problem rather than provide solutions. Programs which are designed to

prevent teenage pregnancy or provide services to teen mothers need to be tailored to the needs of the adolescent population. Concomitant problems such as poverty, education, housing and dysfunctional family systems must be addressed along with the typical adolescent development and parenting needs. Their studies have shown that of inner city adolescent mothers who attend single solution programs, 75% remain in poverty and on welfare. Programs which hand out contraceptives or suggest that teens just say "no" to drugs and sex have little chance of succeeding unless positive alternatives are offered.

Clearly, national, state and local governments have not caught up to the programmatic needs identified in the literature. Until an environment is created that will favor the development of comprehensive programs for adolescent mothers and their infants, it should not be expected that any new models will be forthcoming.

The literature does offer some insight to the value of comprehensive programs by discussing models that are not comprehensive. Porter and Rosenwald (1989) discussed the "Wee Care" program which operates

in a major urban area. This drop-in type program is funded primarily by the State Office of Alcohol and Drug Abuse Programs: an interesting fact since the program focuses on teenage pregnancy issues. This is a clear indication of the substantiated connection between drug abuse and teenage sexual behavior. The program has at its core a focus on helping the adolescent realize that her adolescence is over and that she must become responsible and accountable for her actions. Furstenberg, Brooks and Morgan (1987), in speaking to these very programs showed through a longitudinal study of teen mothers in later life that only 25% of those participating in these programs ever climb out of poverty and off of the welfare rolls. Furstenberg et al. attribute their findings to the pervasive family and societal conditions in which teen mothers continue to live even after attending an effective drop-in program.

Salguero (1980), in his review of programs for adolescent mothers funded by the Administration of Children, Youth and Families, argues that while many programs are available teen mothers often do not know they even exist. Of the programs examined, it was

found that the primary foci were helping mothers complete their adolescent development and the enhancement of parenting skills. Results were inconclusive because attendance at such programs was often irregular. This was attributed to logistical issues such as lack of transportation and day care. Most of the teen mothers interviewed preferred home-based programs over center-based programs because of the logistical complications. Salguero concluded that the most effective programs for adolescent mothers are based on a family systems approach and offer a comprehensive array of services.

Burman and Streett (1982) argue that all efforts to provide services to adolescent mothers and their infants must first confront the adolescence of the mother before trying to intervene on any other level. In order to best meet the needs of both mother and child, they conclude that a comprehensive services program under one roof can provide the best scenario for teen mothers to learn accountability and responsibility. Asghar and Kilbey (1992) concur that comprehensive residential treatment is the best option when it is available. They note, however, that poor

minority women with children do not have the same options as the single white woman would. First, most residential care is expensive, thereby excluding women without financial means or insurance. Secondly, poor women with children would most likely have to put their child(ren) in foster care in order to be admitted. Because they fear that they may be unable to get their child(ren) back after treatment, they choose less desirable outpatient programs.

In his testimony before the Committee on Finance of the United States Senate, the Comptroller General of the United States, Charles A. Bowsher (1990), made the following observations, "To address the problems associated with the growing numbers of drug-exposed infants, pregnant women who use drugs need to be offered comprehensive treatment services. Many health professionals believe comprehensive residential drug treatment that includes prenatal care services is the best approach to helping many women give up drug abuse during pregnancy. This also assures the developing infant the best chance of being born healthy. However, such programs are scarce. Massachusetts officials told us that the lack of residential treatment slots was a

major problem. Only 15 residential treatment slots are available to pregnant addicts statewide" (p. 9-11). Other states reported a similar problem.

The literature is in agreement that in order to provide a long-term solution to the problems of parenting teens and their children and especially those who have been exposed to drug abuse, comprehensive services must be provided. What the literature does not offer is an array of models of existing residential treatment programs to parenting teens because there are few to be studied. It is apparent from the recurring themes of the literature that new models are not emerging because the will to achieve long-term problem resolution has not reached the National Agenda.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals and Expectations

The following goal and expectations were projected for this practicum: an organizational model would be created for the effective delivery of treatment and social services to adolescent drug-exposed mothers and their infant children. It was expected that upon completion of this practicum, the organizational model developed would be used to create a comprehensive services treatment facility for adolescent mothers and their infants. An additional expectation was that a consortium of supporting agencies and organizations would participate in the model development, increasing the possibility of a network of support when the program is actually put into operation.

Expected Outcomes

The expected outcomes for the writer were:

1. To develop an effective model of comprehensive services to serve the subject population that would be consistent with all mandated licensure requirements.

2. To develop a database of government and private agencies and individuals that have previously provided single issue services to adolescent mothers and their infants. They provided consultation and input into the model design to determine that within the comprehensive model's framework, all single issues were identified and addressed.

3. To develop a menu of services consistent with the needs of adolescent mothers and their babies who have had a history of drug-exposure or are at risk of drug-exposure. The menu of services includes educational/vocational training, psycho-social counseling, parenting training and adolescent/child development.

4. To develop evaluation instruments to determine the program's effectiveness and the mother/baby progress in successfully achieving their goals in the program.

Measurement of Outcomes

The outcomes were measured first by developing the materials necessary to meet the mandated licensure requirements of those agencies requiring licensure. Agency approval of the submitted materials was evidence

that the outcome had been achieved. The materials presented for licensure served as the core document for policy and procedures of the comprehensive services model.

Second, an expansive network of government and private agencies and individuals was developed to provide consultation and input into the model design. A data base of pertinent agencies and individuals was created. Feedback was obtained on the various model components from appropriate network sources for incorporation, when appropriate, into the program model and menu of services.

Third, the menu of services was evaluated by submitting it for review and comment to licensing agencies and graduate level schools of social work. A critique form was submitted with the menu of services for feedback.

Fourth, evaluation checklists were created for the purpose of program review. Program review will be conducted semi-annually by the board of directors and the staff of the project. A checklist was created to assist each client mother in assessing the value of the program and the individual level of success

experienced. The checklists, along with the results of a six month follow-up interview, will give an indication of the mother's progress in meeting the requirements of the individual service plan and the extent to which she has continued to make satisfactory progress after discharge from the program.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Solutions

Current organizational models are ineffective for the delivery of treatment, rehabilitation and comprehensive services to drug abusing mothers, ages 15 to 25, and their infant children. Through the review of the literature, two things became immediately apparent: 1) there are some models which have been in repetitive use for at least the last ten years, and 2) recent literature is scarce regarding any new models or model building theory in large part because they have not been developed. On the brighter side, significant work has been done by the business sector in the fields of strategic planning, business plan development and the creation of effective boards of directors. It may be at this juncture of provision of social services and sound business practice that a case can be made for the need for expansion of single service models into comprehensive services models.

An examination of the literature reveals other possible solutions to address the lack of comprehensive

programs for drug exposed women with children. Three basic methods of providing services to adolescent mothers and their infants emerge from the literature. The first method is school based or alternative schools, second is community agency based drop-in centers with some support services and the third is a more comprehensive residential treatment facility.

School-based/alternative school models are discussed by Rothrock and Sung (1980). Their model advocates an alternative school used to provide comprehensive services while providing an environment conducive to remedial education. The expectations of this education plus program are: 1) to reduce the potential for abuse and neglect and other aberrant parenting practices among school age parents by developing nurturing and parenting skills, and 2) to facilitate the normal growth and development of the children of school-age parents through skills and information gained by parents and through the child's experience in the dáy care/child care programs.

In its review of effective programs for parenting teens, The Children's Defense Fund (1987) lists several programs that use education as a core towards high

school completion. All of the programs outlined utilize other government and community assistance programs to augment the services offered in the school setting. Students who show a desire for continued education and who have sufficient family support would be the most likely to benefit.

Hale, Hollier, Levenson and Tirado (1978) suggest that county funded services that respond to the adolescent parent and child in their home is a viable model because of the parent's need to meet the priority needs of herself and her child. Other services are provided to support the family unit by transporting mother/baby to various points of service on a pre-scheduled basis.

Porter and Rosenwald (1989) review a drop-in center model that is operated in conjunction with a local school system and makes use of community services. The focus of the model was to provide information to pregnant or parenting teens about sexuality, sexually transmitted diseases, parenting skills, child development, self care and child care responsibilities, goal setting and promoting healthy relationships.

Asghar and Kilbey (1992) propose a model being used in a northeastern city to provide out-patient comprehensive services. Spearheaded by a local health center and a related municipal hospital, services are provided with a focus on helping drug-exposed women to keep their children. Services are provided to treat substance abuse, provide prenatal, postpartum obstetric and pediatric care, parenting and child development skills, child care on-site and advocacy services to ensure future self-sufficiency. Literacy and nutrition programs are made available as the client is ready to integrate them.

Benas (1975) describes a residential model used by the Salvation Army which provides long-term comprehensive services in a residential setting. This model acknowledges that the adolescent is a "child-mother" and needs time to successfully negotiate her adolescence before being able to successfully parent. Adolescents are trained in parenting skills, and are given the opportunity to complete their education while providing care and developmental opportunities for their infants.

Salguero (1980) reports that of 136 agencies

studied, most provide center based programs to teach adolescent development and to enhance parenting skills. The common thread that is missing in most of these programs is the need for a family systems approach to reinforce other services offered to the adolescent. In the most comprehensive center based program discussed, components included education, parent/child development, monetary incentives for participation, opportunities to be with peers, subsidized day care, a minimum of red tape, and staff members who are sensitive and serve as advocates.

School-based and center-based programs can serve certain segments of the adolescent mother population that are not drug exposed or in need of intensive parenting. Only the most motivated will be likely to succeed in programs that do not offer round-the-clock parenting and support.

It would seem that all of the solutions from the literature rely on community resources and a broad base of funding support. Due to the lack of longitudinal studies, it is difficult to determine if the resources expended in these programs are receiving a payback in terms of client success. Furstenberg et al. (1987)

suggest that only 25% of those in school and community-based programs ultimately climb out of the welfare system.

Drop-in centers as described by Porter and Rosenwald have a set of problems centering around logistics that are also common to residential programs that use community services. It is often difficult to transport a young mother and child from service to service. Because services are not centrally located, clients may find it necessary to miss school or counseling because of the amount of time required for transportation and appointment scheduling. The costs of child care and/or transportation may make participation an economic impossibility for the client.

Comprehensive services provided on an out-patient basis to drug exposed women with children can offer a wide array of services. This is especially true when there is an organizational link to a community health facility. Again, a core problem would be that only the most motivated clients would regularly attend classes and scheduled appointments and drop out rates tend to be quite high.

Those programs that are not residential

comprehensive programs must use caution in the way that they define their mission and identify their clientele. Strategic planning would help them to recognize the limitations of their programs especially when they attempt to offer treatment and support services to adolescents who have a multiplicity of problems in their family systems in addition to their drug addiction.

Description of Selected Solution

The solutions from the literature all have some merit for the adolescent mother/baby families addressed in this practicum. However, only the residential model described by Benas (1975) provides comprehensive social services as well as parenting for the "child-mother" in a family systems context.

The solution selected by this writer was a residential treatment facility model that offers comprehensive social services. The model constructed an organizational framework necessary for the implementation of a program to treat drug exposed adolescent mothers and their infant children. In order to accomplish the goal of an organizational framework suitable for future implementation of a treatment

program, it was first necessary to do a preliminary survey of supporting agencies and organizations to determine both the need and feasibility of the selected model. When feasibility was established, policy and procedures were written in order to comply with state licensure requirements. State licensing entities place particular emphasis on programs which provide comprehensive programs in a cost effective manner. It was also important to the licensing process that a broad base of support be shown from a variety of disciplines and sectors of the community.

Those programs which offered less than comprehensive services were surveyed to determine what services they provided and the reasons why their programs were not more comprehensive. This information was essential to the design of the comprehensive residential model because justification would have to be made for each program component from a cost basis as well as a clinical basis.

A menu of services was developed to reflect the needs of the client and to address the operational realities reflected in the survey. Because of the comprehensive nature of the proposed model, it became

obvious that the only way all of the needed services could be provided was to provide every service under one roof. In so doing we would eliminate the need for transportation logistics and cut costs because staff could be used in more flexible ways to accommodate the client on a 24 hour basis. A holistic menu of services for the client also included services to the family of origin consistent with sound case work practice. The inclusion of family services was missing from most of the programs surveyed but was high on the priority list of all funding and licensure sources.

All of the programs surveyed had few if any evaluation instruments. It was determined that program effectiveness needed to be measured to insure quality control and be a base for longitudinal study. Evaluation instruments were constructed to determine to what extent the client family met the goals of the program.

The selection of a comprehensive residential treatment model, as demonstrated above, was consistent with the goals and expected outcomes stated earlier in this practicum. This model will be more costly to implement on the front end because of the cost of

facilities but should substantially be more cost effective than other program models when the client outcomes are compared to the operational cost of other less comprehensive programs.

Report of Action Taken

Weeks 1-3

An in-depth search was made for agencies with similar program goals and organizational structure to the proposed conceptual model. State and County officials were queried to determine suitable programs for observation. Site visits were made to existing programs to get first hand information relating to program and to discuss the organizational structure and culture of the agencies.

Endorsement for the proposed conceptual model was sought and received from the Child Welfare League of America. The Children's Defense Fund offered consultation on the model and menu of services as did local child welfare agencies and state and county offices for drug abuse prevention. Positive feedback served as an indication of program viability and was used to encourage board of director prospects to join

the board.

Weeks 2-8

Members of the social service disciplines were recruited to the board of directors in order to work at brainstorming and program conceptualizing. The first eight members recruited constituted the legal entity required for incorporation as a non-profit corporation. Core board members generated a set of By-laws and Articles of Incorporation necessary for incorporation and to be the operating guidelines of the organization.

In order to give board members a grounding in their roles as board members, a representative group from the board was selected to attend a regional training conference for non-profit board members. Special emphasis was given to recruiting effective board members and using the board as a fund raising vehicle. Board members received in-depth training in strategic plan development as the basis for formation of the organizational model and long range operational planning.

Weeks 6-12

New board members were recruited to increase board strength to 16 members. In an effort to encourage

diversity and create multiple avenues for fund raising, eight board members were the original core of social service professionals and eight members represented various sectors of the business community. Using the earlier brainstorming and conceptualizing of the core members of the board, an in-depth case statement was developed as an interpretation medium of the philosophy, mission, needs analysis and program components of the proposed model. The Case Statement was used for fund raising and board member recruitment. Documents were filed with the Internal Revenue Service to secure a 501(c)(3) charitable organization tax exempt status. Documents were also filed to receive State sales tax exemption as a charitable organization.

Weeks 12-22

Board membership was increased to 23 members representing the business/corporate community, professional disciplines and various clergy. A more definite structure was given to the board of directors with the formation of three committees: the executive committee, finance and real property, and the policy and procedures committee.

The board of directors had a full day retreat to

do strategic planning. Efforts were made to identify opportunities and potential threats and to evaluate the internal and external climate of the organization. Results of the strategic plan were then used to develop long-range goals and plans. Various board committees used the strategic plan to develop a fund raising strategy, a business plan and requirements for a physical site from which to operate the emerging program. A capital campaign was organized to implement the fund raising strategy over a two year period.

Weeks 23-32

Planning from the capital campaign was put into motion to solicit funds for site acquisition and development of the campus. Additional seed funding was acquired from foundations and church organizations to support an executive director and clerical support staff. This writer was identified and hired to be the executive director. A part time clerical person was also hired. Other support persons were recruited on a volunteer basis to assist with ancillary tasks.

Having acquired the regulations from the State Department of Public Welfare and the Department of Health, a policy and procedures manual was developed.

The policy and procedures manual will be the basis for future agency operations.

Weeks 24-31

Licensure was sought and provisionally obtained from the State Department of Public Welfare and Department of Health. Final licensure will be obtained when the program is ready to operate.

A physical site for program implementation was located in a rural area and negotiations for its acquisition were completed. After several community hearings to clarify the nature of the program and potential risks to the community, zoning approval was obtained.

Efforts to raise funding for site acquisition and campus development continued. An architect was chosen to do conceptual work and model building in order to help sell the project. A summer pool party was held to promote group building within the board and to promote interest in the program concept from potential supporters.

Week 32

A board retreat was held to review and revise the strategic plan. Executive Service Corps volunteers led

the retreat and offered their expertise in fund raising and capital campaign development. A full time consultant was hired to manage the capital campaign in order to maximize the limited amount of time board members could contribute to the solicitation of funds.

Evaluation instruments were developed to assess the program and to gain insight from the clients upon discharge as to their perspective of the program and their success in meeting program criteria. In consultation with Temple University's Institute for Survey Research and the Human Organization Science Institute, an initial assessment, a client treatment experience interview and a six-month follow-up assessment were developed. The instruments listed above are to be used in conjunction with the program's internal intake assessments in order to provide baseline data for longitudinal research.

CHAPTER V

RESULTS, DISCUSSION AND RECOMMENDATIONS

Results

Current organizational models are ineffective for the delivery of treatment, rehabilitation and comprehensive services to drug abusing mothers, ages 15 to 25, and their infant children. Comprehensive programs are woefully lacking in both the quantity of programs available and the quality of services provided in existing programs. Of primary concern are the lack of programs that accept adolescents and the child(ren) of the primary client during treatment.

In order to address this problem, this writer has designed a residential treatment facility model that offers a continuum of comprehensive services. The model constructs an organizational framework necessary for the implementation of a program to treat drug exposed women, ages 15 to 25, and their infant children. To accomplish the design phase, an informal survey was done with local child welfare agency officials, representatives of the Child Welfare League of America, The Children's Defense Fund and community

leaders to ascertain the viability of a long term residential treatment facility and to solicit their feedback. Armed with an array of positive feedback in favor of the proposed solution, a non-profit corporation was formed and the appropriate tax-exempt status obtained.

A board of directors was formed representing a broad array of corporate and professional disciplines. The board of directors then assumed the responsibility for strategic planning, creation of a business plan, operational and capital fund raising campaigns, and the development of policies and procedures consistent with state mandates.

Upon selection of a suitable site for the facility's construction, the board of directors solicited and obtained the necessary support from the community leadership and the neighbors adjoining the selected property. As the executive director, this writer gave oversight and direction to every aspect of board development and organizational evolution.

Outcome 1: To develop an effective model of comprehensive services which will serve the subject population and that will be consistent with all

mandated licensure requirements.

Early in discussions with social work professionals, it became apparent that dual licensure would be required. A license was required from the Department of Public Welfare because we were dealing with some clients under the age of 18 and from the Department of Health because we were doing drug treatment and rehabilitation. Meetings were held with state officials from each department to ascertain how they wanted us to respond to their particular mandates. For instance, the Department of Public Welfare only wanted to establish that a structured organization existed to oversee their requirements for child safety and well being. The Department of Health was much more exacting, requiring that the agency's policy and procedures manual show specifically how treatment would be accomplished, who was responsible for goal implementation and how results would be recorded. The challenge was to blend two sets of regulations into one comprehensive policy and procedures manual.

The manual was organized into six distinct sections: administrative, personnel, case management, education, physical plant and food services. Each

section addressed those mandates that would apply to the day to day operations of the proposed model program.

Members of the board of directors who had expertise in providing social services formed a policy and procedures review committee to critique and edit the manual before submission to the State Departments of Public Welfare and Health in application for licensure. A final edited version was submitted to the two departments for review. Both departments accepted the manual as written as evidence that licensure requirements were met.

Outcome 2: To develop a database of government and private agencies and individuals who have previously provided single issue service to adolescent mothers and their infant children. Feedback provided consultation and input into the model design to determine that within the comprehensive model's framework all single issues were identified and treated.

A database was created of agencies and individuals within the region of the state where the model program will be located. Fifteen different programs were

identified that had similar goals for treating women and children with patterns of substance abuse. Each of the agencies was sent a questionnaire (Appendix A).

Of the 15 agencies that were sent the questionnaire, only nine agencies responded. A second attempt was made to get responses from the six non-respondents. The second attempt was unsuccessful. The information gathered from the nine respondents was revealing though not surprising. A synthesis of the responses is recorded in Table 1.

Table 1
Synthesis of Service Provider Options

What is the age range of female clients accepted for service? 15-18 yrs ___ 18 and older 9 other ___

How long are clients eligible to remain in treatment? 3 mos ___ 6 mos 5 9 mos 3 12 mos 1 longer ___

Are clients allowed to have their children with them during treatment? yes 2 no 7

What type of treatment is provided? Outpatient ___ Residential/Hospital 1 Residential/Non-Hospital 8 Halfway House ___ In Home Treatment ___ Methadone ___

Which of the following services do you provide? If a service is not provided, please indicate the reason why.

	Provided/Reason not provided		
	yes	no	
Drug Free Treatment	6	3	smoking is allowed
Infant Stimulation	0	9	not required or children not accepted
Day Care	2	7	children not accepted
Medical Care	9	0	
Daily Toxicology Screening	1	8	not required
Pre-Natal Care	2	7	pregnant women not accepted
Post-Partum Care	2	7	pregnant women not accepted
Academic Education	3	6	no staff or space

Vocational Training	0	9	no staff or space or funding
Parenting Skills	2	7	children not accepted
Independent Living Skills	9	0	
Sexuality Counseling & Education	4	5	no staff or not required
Family Therapy	1	8	no staff or not in treatment plan
Psychological Services	3	6	referred outside
Recreation	1	8	no space
Follow-up Services after discharge	5	4	referred outside

Outcome 3: To develop a menu of services consistent with the needs of adolescent mothers and their infant children who have had a history of drug-exposure or are at risk of drug exposure.

This outcome was achieved through the use of the data accumulated in consultation with other provider agencies and in consultation with the Child Welfare League of America and the Children's Defense Fund. Input was also sought from members of an advisory committee which represents a variety of disciplines. The primary role of the advisory committee is to be a resource to the agency's board of directors on an as needed basis.

The menu of services contains the following items: (a) medical services, (b) substance abuse treatment, (c) psychological services, (d) sexuality counseling and education, (e) child care/infant stimulation program, (f) parenting training, (g) independent living skills, (h) academic education, (i) vocational training, (j) creation of business and employment opportunities, (k) community living skills, (l) self-expression opportunities/spiritual growth, (m)

recreation, (n) extended family services, and (o) follow-up services.

A critique form (Appendix B) was presented to representatives of two graduate schools of social work along with the menu of services for their review. Evaluators were also asked to ascertain how the menu of services would serve as the basis for an Individual Service Plan (Appendix C) that would be created for each client.

The feedback from the social work evaluators was overwhelmingly positive and enthusiastic. Their remarks were prefaced with such comments as, "Since we are not aware of an existing program which provides such a holistic menu of services, we can endorse these without reservation." No additions were suggested for the menu of services.

Outcome 4: To develop evaluation instruments to determine the program's effectiveness and the mother/baby progress in successfully achieving their goals in the program.

Evaluation checklists were created for the purpose of program review (Appendix D). In addition an evaluation checklist was created to evaluate the degree

to which the client family, mother and baby, has met the requirements of the Individual Service Plan.

The evaluation instrument developed to assess to what extent objectives of the various program components were met will serve as the quality control instrument for the agency. The instrument will be used on a quarterly basis by those staff responsible for a specific program area.

A checklist was also created (Appendix E) to evaluate the degree to which the client or mother/baby family unit has met the requirements of the Individual Service Plan (Appendix C). The checklist acknowledges that not all clients will have need of every item available on the Individual Service Plan. Upon discharge from the program, the case manager and the client will complete the checklists together in order to evaluate the program, ascertain the extent to which the client participated in the program, and expose any issues which could be addressed in follow-up care.

Discussion

Comprehensive residential treatment is essential for women ages 15 to 25 years old who have children, are pregnant, and are in some way drug exposed. The results of this practicum substantiate the need for an organizational model that addresses the numerous problems attached to the subject population.

In the process of the development of the organizational model, it quickly became apparent that many persons in the drug treatment field were overwhelmed with the very concept of a facility designed to do comprehensive treatment services. This is not surprising given the results of the service provider questionnaire examined in the results of Outcome 2. Many organizations set out to provide comprehensive services only to find themselves limited by the facility they have chosen. Certainly the cost factor and availability of suitable locations is a factor in site selection, but it is precisely at this juncture that the organizational model employed in this practicum became critical to its future success.

Some reflections on the process used to create the organizational model will be valuable for future replication. Early in the envisioning process a core group of social service and community leaders were gathered to share their thinking about the concept of comprehensive residential treatment. After several months of research and consultation with the Child Welfare League of America and the Children's Defense Fund, the decision was made to formally organize as a non-profit corporation. By-laws were drafted and federal tax exempt status was acquired. At this point our informal visioning group became the beginnings of a board of directors. Over the course of eight months the board size increased to include corporate and business leaders who would provide expertise outside of the social services genre. Because the board and organization were new, training in the proper role of the board of directors was obtained from a seminar provided by the regional telephone company.

As a result of the training given to the board of directors, they were able to develop several core documents. First a case statement for the organization was developed. The first major effort in composing the

case statement was to describe the organization's mission. The mission statement agreed upon was: "The mission of the organization is to provide comprehensive services for the adolescent mother, ages 15 to 18 at admission, and her child(ren), ranging in ages from infancy to preschool, who are suffering from patterns of substance abuse. These services are provided for a period of one to three years in a residential community setting which allows the adolescent to nurture the mother/child bond while addressing her own therapeutic needs and receiving help to address her child's developmental and medical needs."

Out of the mission statement, the rest of the case statement evolved describing the philosophy of the organization, its inspiration and growth, a needs analysis, description of the program, a listing of the board of directors and an invitation to the philanthropic community to make contributions of financial support. Using the case statement, a strategic plan was developed, using Bryson's (1988) model, to examine the organization's internal and external environments. During the strategic planning process, six categories were agreed upon for study.

The goal was to determine the strengths, weaknesses and goals that the board had in the following areas: (a) program capacity, (b) program components, (c) public relations and volunteerism, (d) fund raising and resource development, (e) board strengthening and (f) organization and administration.

Several significant issues emerged from the strategic planning process. It was determined that no more than 30 women and their children could be adequately provided for without giving the sense of institutionalization. Program components remained as they were outlined in the case statement though some interest was shown in replicating the proven project in other places and creating a program for male drug abusers with children. It was determined that the program would need strong community support as well as numerous volunteers. Because the church seemed to be the best place to satisfy both needs, a staff position was created to be a liaison between the organization, faith communities and the community at large.

When fund raising and resource development were examined, several things became immediately apparent. First, a substantial amount of money would need to be

raised before the doors could be open to clients. Second, it was determined that operational funding would be available from several funding streams and would not be a problem if an adequate facility was constructed first. Third, a change would need to be made in our mission statement if we were to take advantage of more than one funding stream. Consequently, the age range of the clients we would serve was changed from 15 through 18 years of age to 15 through 25 years of age. This change would allow funding to be sought from the State Department of Public Welfare for adolescents up to 18 years of age and funding from the State Department of Health for clients over 18 years of age. Program components would not need to be changed due to the state of arrested adolescence in which substance abusing women tend to remain, irrespective of age, until they are in recovery.

Another category of the strategic plan was in the area of board strengthening. Because of the need for substantial capital funds, it was decided that future board growth would be concentrated toward people with access to funding sources.

The final aspect of the plan focused on organization and administration. Organizational charts were developed by the board to show how both the board and the program would be organized (Appendices F and G). Licensure requirements became more involved because of the change in age range. A board committee was formed to write a policy and procedures manual to satisfy the requirements of the Departments of Public Welfare and Health.

The third core document to be developed was the business plan. While the strategic plan was a process for the organization to look at itself in light of its environment, the business plan was a presentation piece for the business community to look at the organization. The board of directors entered into a consulting relationship with the Executive Service Corps to get objective assistance in writing the business plan and circulating it in the business community. Retired executives make up the Executive Service Corps, volunteering their time to non-profit corporations in need of their wisdom and expertise. The process of developing the business plan helped board members to crystalize their thinking about the goals, objectives

and future direction of the organization. Once written, the business plan had several key components: (a) an Executive Summary of the organization and its mission, (b) a description of the organization, its staffing and key administrators, (c) specifics on how the organization would be managed, (d) a conceptual marketing plan, (e) a description of the organization's program and services, (f) the impact of various economic conditions on the financial health of the organization, and (g) financial statements showing balance sheets, income statements and cash flow statements.

Once all of the organizational documentation was completed, a search began for a facility site. Existing buildings as well as vacant land were considered with the caveat that no less than ten acres would be required for campus development. As was discussed earlier, a primary cause for programs falling short of their comprehensive services goals is that their facilities cannot accommodate more than the basic programs or house necessary staff. With these constraints in mind, the property search focused outside of expensive urban areas where land was scarce.

It was, however, a concern that we not be too far removed from the medical services available in the urban areas. An 18 acre site was found that met all of the organization's requirements as well as have little community resistance to a drug treatment program.

Architectural services were donated to provide conceptual drawings of a suitable campus. A capital campaign consultant was hired to raise the $5 million required for campus construction. The conceptual drawings were used as a sales tool to raise capital funding for the campus construction.

With licensure from the mandated agencies, the organizational model was complete and the program ready for operational implementation. The evaluation instruments to determine program effectiveness and the successful completion of Individual Service Plan goals by the client will be used to ascertain not only program effectiveness but also the appropriateness of the organizational model.

All of the anticipated outcomes were met. Comprehensive residential drug treatment for women ages 15 through 25 and their children will have a greater measure of success than alternative programs when the

organizational model proposed is used to develop the program. Cost effective drug treatment is possible if adequate planning is in place before a program is designed and operated in inadequate facilities. Because poor program design and implementation is a key factor in the high rate of recidivism among drug addicted women, comprehensive planning of new programs and networking with community and governmental entities are essential to the development of drug treatment programs that produce successful clients.

Recommendations

1. State and federal agencies responsible for drug treatment funding should take a pro-active role to ensure that treatment programs have undergone adequate organizational development prior to licensing and/or funding.

2. Governmental funding should be reallocated to encourage programs that provide a comprehensive array of services to their clients.

3. Sample organizational planning models should be made available to emerging organizations through state governments. Because each state has different licensure requirements, the states should assume the

role of educating providers before programs are put into operation.

Dissemination

Results of this practicum have been shared with the organization's board of directors, local and state governmental agencies and representatives of the Child Welfare League of America and the Children's Defense Fund. Further dissemination will occur as child care providers, social workers and drug and alcohol counselors visit the campus for orientation.

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APPENDIX A

SERVICE PROVIDER QUESTIONNAIRE

Name of Agency Date of Response

Agency Address

Name of Person Responding:

What is the age range of female clients accepted for service? _____

How long are clients eligible to remain in treatment?

_____

Are clients allowed to have their children with them during treatment? _____

What type of treatment is provided? Outpatient ____
Residential/Hospital ___ Residential/Non-Hospital ___
Halfway House _____ In home treatment _____
Methadone only _____

Which of the following services do you provide? If a service is not provided, please indicate the reason why.

	Provided	Reason not provided
Drug Free Treatment		
Infant Stimulation		
Day Care		
Medical Care		
Daily Toxicology Screening		
Pre-Natal Care		
Post-Partum Care		
Academic Education		
Vocational Training		
Parenting Skills		
Independent Living Skills		
Sexuality Counseling & Education		
Family Therapy		
Psychological Services		
Recreation		
Follow-up Services after discharge		

Appendix B

CRITIQUE FORM FOR MENU OF SERVICES

Critique Form for Menu of Services

General comments:

Does this menu of services seem to be consistent with the general goals of an Individual Service Plan?

What other components would you suggest for inclusion in the menu of services?

Are there any components in the menu of services that you would not deem appropriate for the proposed client population?

Appendix C

INDIVIDUAL SERVICE PLAN

INDIVIDUAL SERVICE PLAN

Client's name_____

Date of birth_____

Date of placement with agency_____

Date of ISP meeting_____

Date of last ISP_____

Mother's name_____

Address_____

Father's name_____

Address_____

Agency case manager_____

Referring agency_____

Referring agency worker_____

Phone_____

Brief family history:

Custody status_____

Reason for placement_____

_____

_____

Current medications/disabilities_____

_____

_____

Medical insurance # _____

Placement goal and anticipated length of placement_____

_____

_____

_____

Specialized services required_____

_____

_____

Individual Service Plan
Client's Name:_____
Page 2

Medical Services
Objective:

Action To Be Taken	Responsible Person	Date To Be Accomplished

Dental Services
Objective:

Action To Be Taken	Responsible Person	Date To Be Accomplished

Individual Service Plan
Client's Name:_____
Page 3

Substance Abuse Treatment
Objectives:

Action To Be Taken	Responsible Person	Date To Be Accomplished

Psychological Services
Objective:

Action To Be Taken	Responsible Person	Date To Be Accomplished

Individual Service Plan
Client's Name:_____
Page 4

Sexuality Counseling and Education
Objectives:

Action To Be Taken	Responsible Person	Date To Be Accomplished

Parenting Training
Objectives:

Action To Be Taken	Responsible Person	Date To Be Accomplished

Individual Service Plan
Client's Name:_____
Page 5

Extended Family Services
Objective:

Action To Be Taken	Responsible Person	Date To Be Accomplished

Independent Living Skills
Objective:

Action To Be Taken	Responsible Person	Date To Be Accomplished

Individual Service Plan
Client's Name:_____
Page 6

Academic Education
Objective:

Action To Be Taken	Responsible Person	Date To Be Accomplished

Vocational Training
Objective:

Action To Be Taken	Responsible Person	Date To Be Accomplished

Individual Service Plan
Client's Name:_____
Page 7

Child Care/Infant Stimulation
Objective:

Action To Be Taken	Responsible Person	Date To Be Accomplished

Community Living Skills
Objective:

Action To Be Taken	Responsible Person	Date To Be Accomplished

Individual Service Plan
Client's Name:_____
Page 8

Self-Expression Opportunities/Spiritual Growth
Objective:

Action To Be Taken	Responsible Person	Date To Be Accomplished

Recreation
Objective:

Action To Be Taken	Responsible Person	Date To Be Accomplished

Individual Service Plan
Client's Name:_____
Page 9

Interactive Behavior
Objective:

Action To Be Taken	Responsible Person	Date To Be Accomplished

Family Visits
Objective:

Action To Be Taken	Responsible Person	Date To Be Accomplished

Individual Service Plan
Client's Name:_____
Page 10

I understand that I am expected to work toward the goals of this plan and that consistent failure to do so may result in legal action toward the termination of parental rights if the client is a minor child. I understand that this agreement will be forwarded to the courts, as requested, and will be made part of the court record.

If I disagree with this plan, I understand that I have the right to appeal to the Department of Public Health and/or the Department of Health. I understand that I have 15 days from the date of this meeting to notify the County Children and Youth Services or the County Office of Drug and Alcohol Abuse and Prevention of my intent to appeal. Notification to appeal must be in writing. I may be accompanied to a hearing by the spokesperson of my choice.

I understand that I have a right to appeal by requesting a hearing from the Court of Common Pleas. I also understand that I have the right to legal counsel. If I do not have an attorney, I can ask my county agency worker for assistance in obtaining counsel.

I understand that the plan, as presented to me, will be in effect until a ruling is made on my appeal.

I understand that the next meeting to review this Individual Service Plan will be held on at at the following location:

Client's Signature_____
Date_____

Spouse's Signature_____
Date_____

Mother's Signature_____
Date_____

Father's Signature_____
Date_____

Referring Agency Representative_____
Date_____

Agency's Representative_____
Date_____

APPENDIX D

PROGRAM REVIEW ASSESSMENT

Program Review Assessment

Client:
Counselor:
Date:

Indicate for each quarter the level of accomplishment for each criterion listed. Evaluate according to the following scale:

1 - All expectations were met.
2 - Expectations were substantially met.
3 - An effort was made, and some expectations were met.
4 - An effort was made to meet the expectations, but no measure of success was achieved.
5 - No attempt was made to meet expectations.
NA - Criterion is not applicable.

SERVICE/CRITERIA	**QUARTERS**			
Medical Services	1st	2nd	3rd	4th
1) Medical screening completed				
2) Follow-up appointments kept				
3) Prescribed medications taken regularly				
4) Special conditions being treated				
5) Dental exams at 6 mos intervals				
Substance Abuse Treatment	1st	2nd	3rd	4th
1) Detoxification completed				
2) Coping mechanisms in place				
3) Participates in group therapy				
4) Participates in individual therapy				
5) Freely shares within the therapeutic community				
6) Participates in the formation of action steps				
7) Takes action appropriately				
Psychological Services	1st	2nd	3rd	4th
1) Psychological screening completed at intake				

2) Keeps appointments with psychologist
3) Actively participates in treatment

Sexuality Counseling & Education	1st	2nd	3rd	4th
1) Attends assigned classes				
2) Attends counseling sessions				
3) Seeks to know self as a sexual being				
4) Participates in discussions				

Child Care/Infant Stimulation	1st	2nd	3rd	4th
1) Cooperates with child care staff				
2) Makes good use of time while in child care area				
3) Seeks to learn developmental/ coping strategies				
4) Makes use of suggestions by staff during personal time with child to further child's skill development				
5) Is punctual in delivering and picking up child				

Parenting Skills	1st	2nd	3rd	4th
1) Attends parenting classes				
2) Participates actively in parenting classes				
3) Demonstrates parenting skills out of class				
4) Can identify a support network				

Independent Living Skills	1st	2nd	3rd	4th
1) Maintains a daily schedule and personal journal				
2) Can manage money according to a written budget				
3) Can successfully interview for a job				
4) Can fill out employment, rental and other applications				

5) Is able to plan menus and be a smart shopper
6) Keeps child and self clean and practices good hygiene
7) Keeps personal area clean and orderly
8) Participates in assigned general house keeping

Academic Education	1st	2nd	3rd	4th
1) Attends assigned classes				
2) Actively participates in activities and discussions				
3) Accomplishes subject area objectives				
4) Completes out-of-class assignments in a timely manner				

Vocational Training	1st	2nd	3rd	4th
1) Attends all classes or work assignments				
2) Shows interest and understanding of concepts of vocation				
3) Actively participates in discussion and activity				
4) Turns in all assignments in a timely manner				
5) Cooperates with instructor				
6) Interacts positively with class mates				

Business and Employment	1st	2nd	3rd	4th
1) Explored possible employment opportunities				
2) Understands and demonstrates appropriate business demeanor				
3) Demonstrates appropriate working relationship with employer and peers				
4) Works with counselor to schedule and prepare for employment interviews				

Community Living Skills	1st	2nd	3rd	4th
1) Participates in communal activities				
2) Demonstrate ability to access community resources				
3) Shows understanding of the value and use of a support system				

Self Expression/Spiritual Growth	1st	2nd	3rd	4th
1) Uses artistic means to create self-awareness				
2) Engaged in a faith journey with reliance on internal and external creative powers				
3) Shares in reflection and meditation activities				
4) Practices self reflection and daily meditation				
5) Maintains a personal journal				

Recreation	1st	2nd	3rd	4th
1) Participates in scheduled recreation				
2) Shows leadership among peers				
3) Works at group building				
4) Uses competitiveness as a means to encourage team mates and to model positive character traits				

Extended Family Services	1st	2nd	3rd	4th
1) Family shows up for counseling sessions				
2) Client participates actively in sessions				
3) Works toward reconciliation and forgiveness				

Follow-up Service	1st	2nd	3rd	4th
1) Actively participates in formation of follow-up plan				
2) Keeps scheduled appointments				
3) Maintains drug-free lifestyle				
4) Uses community resources				
5) Interacts with support system				
6) Attends AA or NA				
7) Practices good independent living skills				

APPENDIX E

INDIVIDUAL SERVICE PLAN QUALITY REVIEW

Individual Service Plan Quality Review

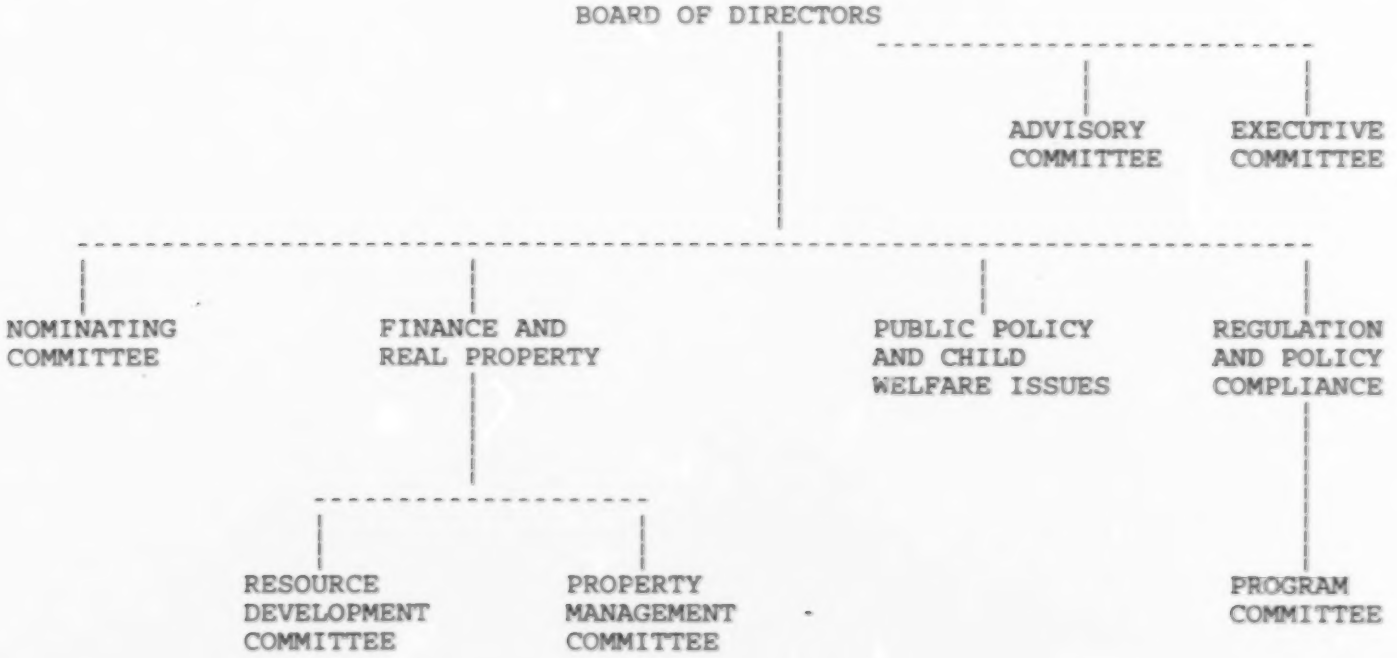
1. Client met all objectives of Individual Service Plan (ISP).
2. Client met a substantial number of objectives.
3. Client attempted and met some objectives.
4. Client attempted to meet objectives but failed.
5. Client did not attempt to meet ISP objectives.

ISP CATEGORY FOR REVIEW	1	2	3	4	5	NA
Medical Services						
Dental Services						
Substance Abuse Treatment						
Psychological Services						
Sexuality Counseling and Education						
Parenting Training						
Extended Family Services						
Independent Living Skills						
Academic Education						
Vocational Training						
Child Care/Infant Stimulation						
Community Living Skills						
Self-expression and Spiritual Growth						
Recreation						
Interactive Behavior						
Family Visits						

APPENDIX F

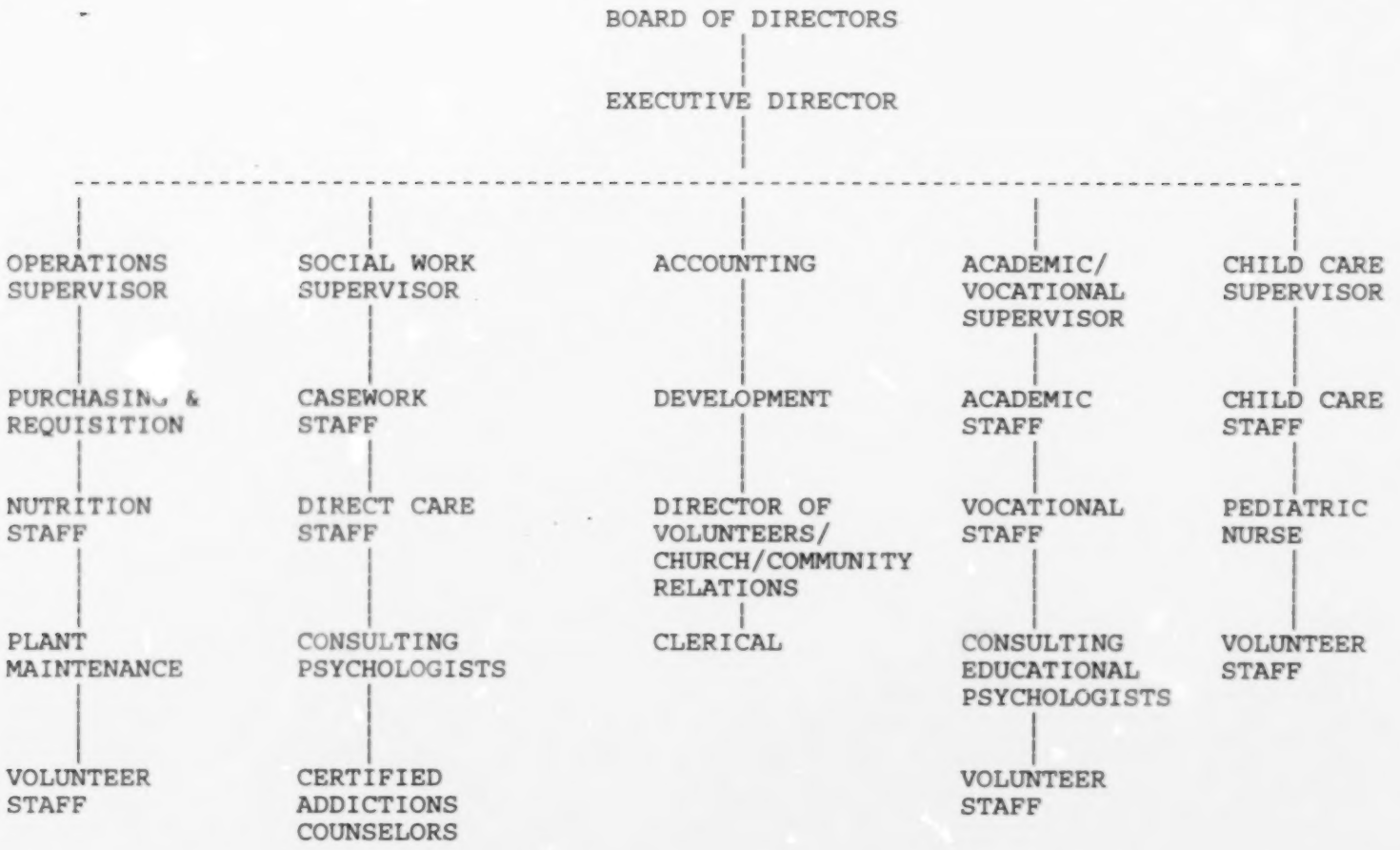
BOARD OF DIRECTORS ORGANIZATIONAL CHART

BOARD OF DIRECTORS' ORGANIZATIONAL CHART



APPENDIX G

PROGRAM ORGANIZATIONAL CHART


BOARD OF DIRECTORS
EXECUTIVE DIRECTOR
OPERATIONS SUPERVISOR
PURCHASING & REQUISITION
NUTRITION STAFF
PLANT MAINTENANCE
VOLUNTEER STAFF
SOCIAL WORK SUPERVISOR
CASEWORK STAFF
DIRECT CARE STAFF
CONSULTING PSYCHOLOGISTS
CERTIFIED ADDICTIONS COUNSELORS
ACCOUNTING
DEVELOPMENT
DIRECTOR OF VOLUNTEERS/ CHURCH/COMMUNITY RELATIONS
CLERICAL
ACADEMIC/ VOCATIONAL SUPERVISOR
ACADEMIC STAFF
VOCATIONAL STAFF
CONSULTING EDUCATIONAL PSYCHOLOGISTS
VOLUNTEER STAFF
CHILD CARE SUPERVISOR
CHILD CARE STAFF
PEDIATRIC NURSE
VOLUNTEER STAFF